FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040709

Facility Name: Alden Lincoln Rehab & H C Ctr

Address: 504 West Wellington Avenue (Number) Chicago (City) 60657 (Zip Code)

County: Cook

Telephone Number: (773) 281 - 6200 **Fax #** (773) 281 - 6745

IDPA ID Number: 36-4003483

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) STEVEN M. KROLL

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,221	3,718	4,683	19,622	8
9	SNF/PED					9
10	ICF	7,665	1,180	332	9,177	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,886	4,898	5,015	28,799	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.19%

D. How many bed-hold days during this year were paid by the Department?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 4,289

Medicare Intermediary Adminastar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	188,784	11,750	9,600	210,134	405	210,539	(5,126)	205,413			1
2	Food Purchase		170,932		170,932	(19,822)	151,110	(14,418)	136,692			2
3	Housekeeping	90,698	21,050		111,748	128	111,876		111,876			3
4	Laundry	52,072	9,972		62,044	154	62,198		62,198			4
5	Heat and Other Utilities			101,907	101,907		101,907	57	101,964			5
6	Maintenance	51,077		66,582	117,659	53	117,712	4,720	122,432			6
7	Other (specify):* Related Party Salary							27,137	27,137			7
8	**TOTAL General Services**	382,631	213,704	178,089	774,424	(19,082)	755,342	12,370	767,712			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,309,629	82,477	4,864	1,396,970	1,342	1,398,312	2,848	1,401,160			10
10a	Therapy					(23,482)	(23,482)		(23,482)			10a
11	Activities	52,368	2,311	2,161	56,840	34	56,874		56,874			11
12	Social Services	40,996			40,996		40,996		40,996			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Related Party Salary							14,569	14,569			15
16	**TOTAL Health Care and Programs**	1,402,993	84,788	28,625	1,516,406	(22,106)	1,494,300	17,417	1,511,717			16
	C. General Administration											
17	Administrative	70,376			70,376		70,376		70,376			17
18	Directors Fees											18
19	Professional Services			348,156	348,156		348,156	(312,497)	35,659			19
20	Dues, Fees, Subscriptions & Promotions			41,038	41,038	(2,543)	38,495	(28,745)	9,750			20
21	Clerical & General Office Expenses	69,557	10,063	16,521	96,141	2,665	98,806	24,340	123,146			21
22	Employee Benefits & Payroll Taxes			278,614	278,614	17,584	296,198	(2,961)	293,237			22
23	Inservice Training & Education											23
24	Travel and Seminar			444	444		444	8,327	8,771			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			111,799	111,799		111,799	125	111,924			26
27	Other (specify):* Related Party Salary			(13,258)	(13,258)		(13,258)	228,089	214,831			27
28	**TOTAL General Administration**	139,933	10,063	783,314	933,310	17,706	951,016	(83,322)	867,694			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,925,557	308,555	990,028	3,224,140	(23,482)	3,200,658	(53,535)	3,147,123			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr #0040709 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,426	33,426		33,426	9,909	43,335			30
31	Amortization of Pre-Op. & Org.							805	805			31
32	Interest			41,209	41,209		41,209	(1,495)	39,714			32
33	Real Estate Taxes			118,500	118,500		118,500	5,719	124,219			33
34	Rent-Facility & Grounds			530,248	530,248		530,248		530,248			34
35	Rent-Equipment & Vehicles			8,571	8,571		8,571	14,213	22,784			35
36	Other (specify):*											36
37	**TOTAL Ownership**			731,954	731,954		731,954	29,151	761,105			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		218,129	461,215	679,344	23,482	702,826	(188,662)	514,164			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		3		3		3	(3)				41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		218,132	513,775	731,907	23,482	755,389	(188,665)	566,724			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,925,557	526,687	2,235,757	4,688,001		4,688,001	(213,049)	4,474,952			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Alden Nursing Center - Lincoln Park 004-0709 PG24
Reporting Period Beginning 01/01/05
Reporting Period Ending 12/31/05

Reclassifications: PGs 3 & 4

From Line	To Line	Amount	Description
22		(2,238.00)	Uniform
	1	405.00	Uniform
	3	128.00	Uniform
	4	154.00	Uniform
	6	53.00	Uniform
	10	1,342.00	Uniform
	11	34.00	Uniform
	21	122.00	Uniform
	22	19,822.00	Employee Meal
2		(19,822.00)	Employee Meal
10		(23,482.00)	Oxygen
	39	23,482.00	Oxygen
	21	143.00	employee background check
20		(143.00)	employee background check
	21	2,400.00	eHealth Data Solutions
20		(2,400.00)	eHealth Data Solutions
Total		-	

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(77)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(661)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,306)	21		17
18	Fines and Penalties	(1,360)	32		18
19	Entertainment	(941)	20		19
20	Contributions	391	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,544)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	13,258	27		24
25	Fund Raising, Advertising and Promotional	(28,495)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,735)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(146,267)	various	34
35	Other- Attach Schedule	(42,047)	5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (188,314)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (213,049)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Lincoln Rehab & H C Ctr

ID# 0040709

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late Fees on Utilities	$ (1,440)	5	1
2	Gift shop expenses (GL 6944)	(3)	41	2
3	Intercompany interest (GL 7031)	(37,656)	32	3
4	Misc income-unclaimed property(policy benefit) (GL497	(2,961)	22	4
5	Vendor Sett/Blackman Kallick Acctg. Fees (GL7143)	2,588	21	5
6	Vendor Sett/Blackman Kallick Acctg. Fees (GL7143)	(2,588)	19	6
7	Vendor Sett/Blackman Kallick Acctg. Fees (GL7143)	780	21	7
8	Vendor Sett/Blackman Kallick Acctg. Fees (GL7143)	(780)	19	8
9	Correct Depreciation expense to detail	13	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(42,047)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(5,126)	0	0	0	0	0	0	0	(5,126)	1
2	Food Purchase	(661)	0	0	(13,757)	0	0	0	0	0	0	0	(14,418)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,440)	0	1,497	0	0	0	0	0	0	0	0	57	5
6	Maintenance	0	0	4,458	0	0	0	262	0	0	0	0	4,720	6
7	Other (specify):*	0	0	22,443	4,694	0	0	0	0	0	0	0	27,137	7
8	**TOTAL General Services**	(2,101)	0	28,398	(14,189)	0	0	262	0	0	0	0	12,370	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	3,834	(986)	0	0	0	0	0	0	2,848	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	14,569	0	0	0	0	0	0	0	0	14,569	15
16	**TOTAL Health Care and Programs**	0	0	14,569	3,834	(986)	0	0	0	0	0	0	17,417	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,912)	0	(305,585)	0	0	0	0	0	0	0	0	(312,497)	19
20	Fees, Subscriptions & Promotions	(29,045)	0	300	0	0	0	0	0	0	0	0	(28,745)	20
21	Clerical & General Office Expenses	62	0	15,728	4,092	4,458	0	0	0	0	0	0	24,340	21
22	Employee Benefits & Payroll Taxes	(2,961)	0	0	0	0	0	0	0	0	0	0	(2,961)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,327	0	0	0	0	0	0	0	0	8,327	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	125	0	0	0	0	0	0	0	0	125	26
27	Other (specify):*	13,258	0	203,733	6,056	5,042	0	0	0	0	0	0	228,089	27
28	**TOTAL General Administration**	(25,598)	0	(77,372)	10,148	9,500	0	0	0	0	0	0	(83,322)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,699)	0	(34,405)	(207)	8,514	0	262	0	0	0	0	(53,535)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	13	0	8,035	0	1,861	0	0	0	0	0	0	9,909	30
31	Amortization of Pre-Op. & Org.	0	0	805	0	0	0	0	0	0	0	0	805	31
32	Interest	(39,093)	0	35,126	0	838	1,634	0	0	0	0	0	(1,495)	32
33	Real Estate Taxes	0	0	3,275	0	2,444	0	0	0	0	0	0	5,719	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	14,213	0	0	0	0	0	0	0	0	14,213	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,080)	0	61,454	0	5,143	1,634	0	0	0	0	0	29,151	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(46,189)	(28,534)	(113,939)	0	0	0	0	0	(188,662)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(3)	0	0	0	0	0	0	0	0	0	0	(3)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(3)	0	0	(46,189)	(28,534)	(113,939)	0	0	0	0	0	(188,665)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,782)	0	27,049	(46,396)	(14,877)	(112,305)	262	0	0	0	0	(213,049)	45

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services	100%	See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$ 313,877	Alden Management Services		$ 8,292	$ (305,585)	15
16	V	21	Gen'l & Admin		Alden Management Services		15,728	15,728	16
17	V	5	Utilities		Alden Management Services		1,497	1,497	17
18	V	6	Repair/Mainten.		Alden Management Services		4,458	4,458	18
19	V	24	Travel/Seminar		Alden Management Services		8,327	8,327	19
20	V	26	Insurance		Alden Management Services		125	125	20
21	V	20	Dues/Subscriptions		Alden Management Services		300	300	21
22	V	30	Depreciation		Alden Management Services		8,035	8,035	22
23	V	31	Amortization		Alden Management Services		805	805	23
24	V	33	Real Estate Taxes		Alden Management Services		3,275	3,275	24
25	V	35	Rent-Equip & Vehic		Alden Management Services		14,213	14,213	25
26	V	32	Interest		Alden Management Services		35,126	35,126	26
27	V	7	Gen'l Service Salary		Alden Management Services		22,443	22,443	27
28	V	15	Health Care Salary		Alden Management Services		14,569	14,569	28
29	V	27	Gen'l & Admin Salary		Alden Management Services		203,733	203,733	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 313,877			$ 340,926	$ * 27,049	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Consultant	$ 9,600	Prism Healthcare		$ 4,474	$ (5,126)	15
16	V	2	Tube Feeding	23,868	Prism Healthcare		10,111	(13,757)	16
17	V	10	Equipment rental - patient care	3,060	Prism Healthcare		6,894	3,834	17
18	V	39	Ancillary supplies	61,547	Prism Healthcare		15,358	(46,189)	18
19	V	7	Dietary Sal & Wages		Prism Healthcare		4,694	4,694	19
20	V	27	Gen & Admin Salary				6,056	6,056	20
21	V	21	Gen & Admin Expenses				4,092	4,092	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 98,075			$ 51,679	$ * (46,396)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 80,680	Forum Extended Care II		$ 114,827	$ 34,147	15
16	V	39	IV	72,551	Forum Extended Care II		10,598	(61,953)	16
17	V	39	Wound Vac	3,352	Forum Extended Care II		2,624	(728)	17
18	V	10	House Stock	3,204	Forum Extended Care II		2,842	(362)	18
19	V	10	Pharm Consult	4,864	Forum Extended Care II		4,240	(624)	19
20	V	27	Employ Vaccin	219	Forum Extended Care II		171	(48)	20
21	V	27	G & A Salary		Forum Extended Care II		5,090	5,090	21
22	V	21	General & Administrative		Forum Extended Care II		4,458	4,458	22
23	V	32	Interest		Forum Extended Care II		838	838	23
24	V	33	Real Estate Tax		Forum Extended Care II		2,444	2,444	24
25	V	30	Depreciation		Forum Extended Care II		1,861	1,861	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 164,870			$ 149,993	$ * (14,877)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		39	Therapy	$ 455,600	Community Physical Therapy		$ 341,661	$ (113,939)	15
16	V		32	Interest		Community Physical Therapy		1,634	1,634	16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 455,600			$ 343,295	$ * (112,305)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs and maintenance	$ 11,184	Alden Bennet Constructions		$ 11,446	$ 262	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,184			$ 11,446	$ * 262	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NURSING CENTER - LINCOLN PARK **# 004-0709** **Report Period Beginning** 01/01/04 **Ending:** 12/31/05

RELATED NURSING HOMES	
Name	**City**
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Waterford	Aurora
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingdale
Alden of Old Town West	Bloomingdale
Alden Trails	Bloomingdale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governors' Park	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	**City**	**Type of Business**
The Forum Prof. Center	Chicago	Office rental
Prism Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President	CEO	100.00	135,986	1.008	2.52	salary	$ 3,514	27-7	1
2	Lauren Magnussen	Clinical Coordinator	Nursing	A	73,846	1.008	2.52	salary	1,908	15-7	2
3	Terry Magnussen	Maintenance Supr	Maint.	A	50,203	1.008	2.52	salary	1,297	7-7	3
4											4
5											5
6											6
7	a. President and sole stockholder of Alden Management Services, Inc.										7
8	b. Daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	$ 6,719		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden management Services, Inc.
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286 - 3883
Fax Number: (773) 286 - 3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See Page 8A (also on Page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Therapeutic Systems (GL7059)		X	working capital			$	$			$ 2,193	1
2												2
3												3
4												4
5												5
	Working Capital											
6	rel party-AMS & AMS therapy	X		working capital							35,126	6
7	related party-CPT	X		working capital							1,634	7
8	related party-FECII	X		working capital							838	8
9	TOTAL Facility Related						$	$			$ 39,791	9
	B. Non-Facility Related*											
10	offset interest expense with interest income (GL4946/4975)										(77)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (77)	14
15	TOTALS (line 9+line14)						$	$			$ 39,714	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	119,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	118,016	2
3. Under or (over) accrual (line 2 minus line 1).	$	(984)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	121,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	120,616	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	145,292	8
	2001	149,072	9
	2002	150,743	10
	2003	115,451	11
	2004	118,016	12

accrual based on 3% increase over prior year bill.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Lincoln Rehab & H C Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040709

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286 - 3883 FAX #: (773) 286 - 3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-108-023-0000	Nursing home facility	$ 118,016.00	$ 118,016.00
2.	SEE	Related Party - Alden Management	$ 130,007.00	$ 3,275.00
3.	ATTACHED	Related Party - Forum	$ 15,792.00	$ 328.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 263,815.00	$ 121,619.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 B. General Construction Type: Exterior brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 14,541	$	25	$	$	$ 14,541	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler heads			1995	1,832	73	25	73		751	9
10	Roof repairs			1995	2,000	167	10	167		2,000	10
11	Installed Electric AMPS			1996	1,870		5			1,870	11
12	Signs			1996	1,800	180	10	180		1,695	12
13	Water Heater			1997	6,180		5			6,180	13
14	Replace Pipes			1997	5,949		5			5,949	14
15	Exhaust Fans			1997	8,403		5			8,403	15
16	Washing machine motor			1998	1,576	197	8	197		1,543	16
17	ABC (General construction) Major repairs/improvement			1999	5,713	571	10	571		3,713	17
18	ABC (General construction) Major repairs/improvement			1999	2,326	233	10	233		1,493	18
19	ABC (General construction) Major repairs/improvement			1999	2,092	209	10	209		1,342	19
20	ABC (General construction) Major repairs/improvement			1999	1,870	187	10	187		1,153	20
21	ABC (General construction) Major repairs/improvement			1999	12,658	1,266	10	1,266		7,806	21
22	ABC (General construction) Major repairs/improvement			1999	2,250	225	10	225		1,369	22
23	ABC (General construction) Major repairs/improvement			1999	10,225	1,022	10	1,022		6,220	23
24	Climate Services (exhaust fan)			1999	2,280		5			2,280	24
25	Oxygen exhaust system			2000	8,555	1,069	8	1,069		6,327	25
26	Elevator door repair			2000	1,518	151	5	151		1,518	26
27	Lawn Sprinkler			2000	15,500	620	25	620		3,307	27
28	ABC (General construction) Major repairs/improvement			2000	6,937	1,156	5	1,156		6,937	28
29	ABC (General construction) New hot water system			2000	49,596	2,480	20	2,480		14,466	29
30	ABC (General construction) Replace showers			2000	23,903	2,390	10	2,390		12,748	30
31	Replace Fire Pump			2001	3,230	162	20	162		808	31
32	14 Kilowatt water heater booster			2001	2,783	278	10	278		1,206	32
33	ABC (General construction) Major repairs/improvement			2001	3,402	680	5	680		3,061	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Capps Plumbing (pipe & wall repair)	2002	$ 1,985	$ 397	5	$ 397	$	$ 1,290	37
38	ABC (misc construction work)	2002	3,442	688	5	688		2,294	38
39	ABC (repair ejector pump)	2002	7,893	1,579	5	1,579		5,131	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		560	40
41	TNS (DSL Cable)	2004	1,358	271	5	271		520	41
42	ABC (1st Floors Stairs)	2004	1,699	170	10	170		184	42
43	Oak Fire security System, new base dual zone card	2005	1,350	23	5	23		23	43
44	Washtown (repair Washer motor)	2005	1,563	130	5	130		130	44
45	ABC (repair Mop basin)	2005	1,613	134	5	134		134	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 223,167	$ 16,873		$ 16,873	$	$ 128,953	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 223,167	$ 16,873		$ 16,873	$	$ 128,953	1
2	Related Party-Forum:								2
3	Leasehold Improvement-Remodeling	1980	11,034		15			11,034	3
4	Leasehold Improvement-Remodeling	1980	17,284		20			17,284	4
5	Leasehold Improvement-Tenant Improvement	1987	893		13			893	5
6	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	6
7	Leasehold Improvement-Roof	1994	3,203	200	16	200		2,204	7
8	Leasehold Improvement-Build.Improv.	1996	1,129	71	16	71		702	8
9	Leasehold Improvement-Asphalting	2000	88		3			88	9
10	Leasehold Improvement-DAI	2001	154	15	10	15		64	10
11	Leasehold Improvement-Bathrooms	2002	667	76	7	76		242	11
12	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		491	12
13	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,801	329	7	329		465	13
14	Leasehold Improvement-Add-on Improvement, fixture base	1980	71		23			71	14
15	Leasehold Improvement-Add-on Improvement, fixture base	2001	123	25	5	25		117	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	Related Party-AMS:							5,938	25
26	Leasehold Improvement-Remodeling	1993	5,938		7			1,997	26
27	Leasehold Improvement-Remodeling	2002	4,861	694	7	694		2,072	27
28	Leasehold Improvement-Remodeling	2003	5,085	726	7	726			28
29									29
30									30
31									31
32	Forum Extended Care, LLC-building/building improv	1999	12,928	306	30	306		2,139	32
33									33
34	TOTAL (lines 1 thru 33)		$ 304,403	$ 19,480		$ 19,480	$	$ 189,093	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 166,808	$ 19,991	$ 19,991	$	varies	$ 81,888	71
72	Current Year Purchases	26,033	1,861	1,861		varies	1,861	72
73	Fully Depreciated Assets	103,636	1,892	1,892		varies	103,636	73
74								74
75	TOTALS	$ 296,477	$ 23,744	$ 23,744	$		$ 187,385	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party AMS	various: bus/autos	1998-2004	$ 4,706	$ 111	$ 111	$		$ 4,638	76
77										77
78										78
79										79
80	TOTALS			$ 4,706	$ 111	$ 111	$		$ 4,638	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 605,586	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,335	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,335	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 381,116	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TL Enterprises
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		96		$ 648,748	16		3
4	Additions							4
5								5
6								6
7	TOTAL		96		$ 648,748 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Purchase option deposit *

10. Effective dates of current rental agreement:
Beginning 03/01/95
Ending 03/01/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 728,248
13.	/2007	$ 728,248
14.	/2008	$ 728,248

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,571 Description: Copy machine lease $8,571
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19	related party - AMS	various	#######	14,213	19
20					20
21	TOTAL		$ #######	$ 14,213	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nurse on site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 284,756	$		$ 284,756	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,977			15,977	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			154,869			154,869	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see Pg 16A	# of prescrpts				114,827		114,827	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): SeSupport (CPT)					(113,940)	57,675		(56,265)	13
14	TOTAL			$		$ 341,662	$ 172,502		$ 514,164	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Page 16
Col 5: PT,OT, & ST
XIV. Special Services (Direct Cost) Col 6: Supplies

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.	
1. OT	39-3	To Co	284,756.00
2. ST	39-3	To Co	15,977.00
3.			
4. PT	39-3	To Co	154,868.44
5.			
6.			
7.			
8.			
Phamacy Supplies per GL			80,680.40
Manual Input from Related Party- Forum Drugs			34,147.00
9. Total to line 9 Pharmacy	See Pg 16A	To Co	114,827.40
10.			
11.			
12. Exceptional Care-Salaries:	See pg 16A	To Co	0.00
12. Exceptional Care-Supplies:	See pg 16A	To Co	0.00
Total Exceptional Care (Line 12, Col 8)			0.00
13. Other:	See Pg 16A		
13. Col 5: Manual Input: Related Party - CPT		To C	-113940
Other			143,063.17
Manual Input: Related Party - Prism			(46,189.00)
Manual Input: Related Party FECII - I.V.			(61,953.00)
Manual Input: Related Party FECII - Wound Vac			(728.00)
Oxygen, from reclass worksheet			23,482.00
13. Col 6: Supplies Total		To Co	57,675.17
13. Total Line 13, Column 8			(56,264.83)
14. Total			514,164.01

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (177,166)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	880,269		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,296		6
7	Other Prepaid Expenses	13,054		7
8	Accounts Receivable (owners or related parties)	1,935,635		8
9	Other(specify): Due from Third Parties	91,182		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,747,270	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	290,879		15
16	Equipment, at Historical Cost	213,539		16
17	Accumulated Depreciation (book methods)	(316,284)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	137,509		21
22	Other Long-Term Assets (spe Purchase Option	288,000		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 613,643	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,360,913	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,168,205	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	109,372		28
29	Short-Term Notes Payable	12,809		29
30	Accrued Salaries Payable	193,184		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,161		31
32	Accrued Real Estate Taxes(Sch.IX-B)	119,484		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accr ins, exps, idpa, sales tax, etc	387,434		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,000,649	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,000,649	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,360,264	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,360,913	$	48

***(See instructions.)**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,280,372	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,280,372	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	79,892	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 79,892	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,360,264	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,474,544	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,474,544	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	244,520	6
7	Oxygen	22,075	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 266,595	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	465	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(160)	19
20	Radiology and X-Ray		20
21	Other Medical Services	15,241	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,546	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	77	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 77	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Recovery of Bad debt	6,352	28
28a	Write off of old Amounts Due and Misc Income	4,779	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,131	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,767,893	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	774,424	31
32	Health Care	1,516,406	32
33	General Administration	933,310	33
	B. Capital Expense		
34	Ownership	731,954	34
	C. Ancillary Expense		
35	Special Cost Centers	679,347	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,688,001	40
41	**Income before Income Taxes (line 30 minus line 40)****	79,892	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 79,892	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,080	$ 71,970	$ 34.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,543	20,516	601,859	29.34	3
4	Licensed Practical Nurses	5,128	5,500	109,882	19.98	4
5	CNAs & Orderlies	42,641	46,137	469,185	10.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,048	2,056	34,814	16.93	9
10	Activity Assistants	1,928	2,056	17,554	8.54	10
11	Social Service Workers	1,976	2,072	40,996	19.79	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	40,342	19.40	13
14	Head Cook	1,080	1,206	15,428	12.79	14
15	Cook Helpers/Assistants	12,292	13,296	133,014	10.00	15
16	Dishwashers					16
17	Maintenance Workers	1,728	2,080	51,077	24.56	17
18	Housekeepers	8,441	9,166	90,697	9.89	18
19	Laundry	5,555	6,094	52,072	8.54	19
20	Administrator	1,760	2,024	70,376	34.77	20
21	Assistant Administrator					21
22	Other Administrative	1,966	2,110	44,277	20.98	22
23	Office Manager	11	11	88	8.00	23
24	Clerical	2,972	3,023	25,193	8.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,912	1,976	34,204	17.31	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Alzheimer Aid	2,020	2,124	22,529	10.61	33
34	TOTAL (lines 1 - 33)	116,977	125,607	$ 1,925,557 *	$ 15.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	800/Monthly	$ 9,600	1-3	35
36	Medical Director	1,800/Monthly	21,600	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	43	2,304	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	722	11-3	44
45	Social Service Consultant	16	702	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	75	$ 34,928		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tess Sagaidoro	Administrator		$ 52,995
Michael Gottesman	Administrator		17,381
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,376

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AMS	Management Fees	$ 313,877
BDO Seidman	Accounting Fees	15,425
Ken Fisch/Barry Greenberg	Legal Services	13,295
Administar	Billing Services	1,988
Medi.Com	Billing Consultant	2,428
SMS	Billing Consultant	1,143
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 348,156

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,713
Unemployment Compensation Insurance	25,618
FICA Taxes	141,952
Employee Health Insurance	16,522
Employee Meals	19,822
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,552
Union Health & Welfare	24,144
Dental, Life & Pension	14,076
Misc Tuition	1,260
Drug Test, 401K Match, Vaccinations	1,539
Unclaimed Property Refund	(2,961)
TOTAL (agree to Schedule V, line 22, col.8)	$ 293,237

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	839
Health Care Worker Background Check	
(Indicate # of checks performed 12)	87
Surety Bond Fees, Sec of State (Dues & Subs)	480
IL Health Care Assoc	5,299
Related Party AMS	300
AMS Billings	2,745
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,750

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto & Travel	205
Related Party AMS	8,327
Seminar Expense	
Alzheimers Assoc	239
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,771

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Climate Service-Pipeing	9/95	$ 1,809	5	$	$	$	$	$	$	$	$	$
2	Painting	9/95	2,478	3									
3	Painting	11/95	4,500	3									
4	Painting	12/95	1,497	3									
5	Onassis (painting)	1/96	1,369	3									
6	Climate Service, Inc.(boil)	1/96	2,015	15	134	134	134	134	134	134	134	134	134
7	Onassis (painting)	2/96	1,541	3									
8	Great Lakes Plumbing(fix	3/96	1,739	20	87	87	87	87	87	87	87	87	87
9	Onassis (painting)	3/96	1,360	3									
10	Superior Painting & Déco	3/96	3,400	3									
11	Superior Painting & Déco	5/96	1,626	3									
12	Superior Painting & Déco	6/96	1,534	3									
13	Superior Painting & Déco	7/96	1,566	3									
14	Superior Painting & Déco	7/96	1,671	3	continued on page 22A, includes grand total…								
15	Superior Painting & Déco	8/96	1,627	3									
16	Superior Painting & Déco	9/96	907	3									
17	Superior Painting & Déco	9/96	950	3									
18	Building Plumbing &Heat	10/96	1,831	15	122	122	122	122	122	122	122	122	122
19	Onassis (painting)	12/96	1,606	3									
20	TOTALS		$ 35,026		$ 343	$ 343	$ 343	$ 343	$ 343	$ 343	$ 343	$ 343	$ 343

Facility Name & ID Number: Alden Nursing Center - Lincoln Park Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Climate Serv (repair boiler)	Feb-97	1,644	3									
2	Climate Serv (repair/insulate pip	Apr-97	2,348	3									
3	Climate Serv(insulation-remove	Jun-97	3,865	3									
4	Climate Serv(install circulating p	Sep-97	2,585	3									
5	Appliance(air conditioning for ki	Aug-97	2,412	3									
6	Great L.P.(remove & install pum	Dec-97	2,595	3									
7	Appliance C.(a/c for kitchen)	May-98	3,702	3									
8	CSI(install ductwork for dryer ex	Sep-98	2,670	3									
9	Custom A.C. (carpeting)	Dec-98	2,940	3									
10	Custom A.C.	Dec-98	192	3									
12	ABC(repair floor and roof)	9/00	10,285	3	3,428	2,286							
13	ABC(misc. construction job)	11/00	8,927	3	2,976	2,480							
14	GT Mechanical(replace motor)	11/02	1,122	3	62	374	374	312					
15	Painting > $1,500 --1999	7/99	11,700	3	1,950								
16	Painting > $1,500 --2000	7/00	6,413	3	2,138	1,069							
17													
18													
19	Totals from Page 22 . . .		35,026		343	343	343	343	343	343	343	343	343
20	GRAND TOTALS		98,425		10,897	6,552	717	655	343	343	343	343	343

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Healthcare Association $5,299**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,655** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **52,560**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,822** Has any meal income been offset against related costs? **no** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BDO Seidman, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.